Nos. 93-115, 93-193, 93-194, 93-210

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In The

Supreme Court of the United States

October Term, 1993

NYSA-ILA WELFARE FUND, *et al.*,

Petitioners,

vs.

FRANCIS J. DUNSTON, in her capacity as NEW JERSEY COMMISSIONER OF HEALTH, *et al.*,

Respondents.

*On Petition for Writ of Certiorari to the United States Court of Appeals for the Third Circuit**

BRIEF IN OPPOSITION FOR RESPONDENT NEW JERSEY HOSPITAL ASSOCIATION AND THE RESPONDENT HOSPITALS

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* Case captions for additional petitions are referenced on inside front cover.

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NEW JERSEY CARPENTERS WELFARE FUND, *et al.*,

Petitioners,

vs.

FRANCES J. DUNSTON, in her capacity as NEW JERSEY COMMISSIONER OF HEALTH, *et al.*,

Respondents.

TRUSTEES OF THE WELFARE TRUST FUND, LOCAL UNION NO. 475, *et al.*,

Petitioners,

vs.

FRANCES J. DUNSTON, in her capacity as NEW JERSEY COMMISSIONER OF HEALTH, *et al.*,

Respondents.

UNITED WIRE, METAL & MACHINE HEALTH AND WELFARE FUND, *et al.*,

Petitioners,

vs.

MORRISTOWN MEMORIAL HOSPITAL, *et al.*,

Respondents.

QUESTIONS PRESENTED FOR REVIEW

1. Whether the Court of Appeals correctly applied this Court's prior precedents in holding that a generally applicable hospital rate setting statute which is not intended to regulate the conduct of self-insured employee benefit plans, does not single out such plans for special treatment, does not predicate rights and obligations upon the existence of such plans and does not dictate or restrict the manner in which such plans administer their affairs, is not preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*

2. Whether the Court of Appeals correctly applied this Court's prior precedents in holding that a generally applicable hospital rate setting statute which adjusts the benefits and burdens of economic life to promote the common good, does not impact upon plan participants in an inappropriate way and which constitutes a continuation of New Jersey's long standing regulation of health care matters, does not cause a taking of property without just compensation in violation of the Fifth Amendment of the United States Constitution.

PARTIES TO THE PROCEEDINGS

All parties to these proceedings appear in the caption of the decision of the United States Court of Appeals for the Third Circuit, which is contained in petitioners' appendix at pages A-1 through A-5. Because of the large number of parties, the list will not be reproduced herein. In accordance with Supreme Court Rule 29.1, a list of the respondents' parent corporations and subsidiary corporations that are not wholly owned is reproduced in the appendix to this brief.

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STATEMENT OF THE CASE

This case involves the issue of whether certain components of New Jersey's comprehensive statutory scheme governing hospital rate setting are preempted by ERISA, 29 U.S.C. § 1001, *et seq.*, or create an unlawful taking of property without just compensation in violation of the Fifth Amendment to the United States Constitution.

A. Hospital Rate-Setting in New Jersey

New Jersey's Health Care Facilities Planning Act, N.J.S.A. 26:2H-1, *et seq.* (the "Act") was enacted by the New Jersey Legislature in 1971.[1] The declared public policy underlying the Act was:

> that hospital and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health.

N.J.S.A. 26:2H-1 (1992).[2] (Respondents' Appendix, *infra*, at A-8). In order to attain cost-containment and efficiency, the Act authorized the Commissioner of the New Jersey Department of

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1. On November 30, 1992, the Legislature enacted the Health Care Reform Act of 1992, L. 1992, ch. 160. As a result of this legislation, the State of New Jersey no longer regulates the establishment of hospital rates. While the specific statutory provisions challenged herein have been superseded, petitioners seek restitution of monies paid while those provisions were in effect, and many hospitals have not been paid in full for services rendered pending the final outcome of this litigation. As a result, the Court of Appeals determined that this case was not moot.

2. Pertinent sections of the Act have been reproduced in respondents' appendix.

Health (the "Commissioner") to regulate certain costs of health care services, including the establishment of hospital rates. N.J.S.A. 26:2H-5, 26:2H-18, and 26:2H-18.1 (1992) (Resp. A-15-23).

As originally enacted in 1971, the Act authorized the Commissioner to set hospital rates only for individuals whose care was paid for by Blue Cross and certain governmental programs, such as Medicaid. L. 1971, c. 136, § 18. (Resp. A-23-24). The rates were based on the actual cost of services provided by hospitals, a method which furnished only limited incentives to improve efficiencies in hospital operation. Under the 1971 Act, the state had no authority over the rates that hospitals charged patients who had private insurance coverage or the uninsured. Consequently, these groups sometimes paid higher rates for the same services. *See generally Borland v. Bayonne Hospital,* 72 N.J. 152, 159 (1977), *cert. denied,* 434 U.S. 817 (1977).

In order to achieve greater control over the increasing cost of hospital services, reduce the disparity in rates charged to patients whose care was fully or partially paid for by different payors, and alleviate the financial burden on hospitals serving indigent patients, the New Jersey Legislature amended the Act by establishing a new system of hospital rate-setting controlling charges to all patients receiving hospital services. L. 1978, c. 83.[3] Unlike the former system, Chapter 83 applied to all payors, not just to individuals whose care was paid for by Blue Cross and Medicaid. Chapter 83 contained an express recital that cost containment was a stated objective of the Act. N.J.S.A. 26:2H-1 (1992). (Resp. A-8). The statute also had an express goal of promoting the fiscal solvency of hospitals. *Id.* Administration of the new rate-setting system was delegated to the New Jersey Department of Health ("DOH").

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3. These amendments have become known as "Chapter 83".

The rate-setting system set a prospective rate of reimbursement, in advance of actual treatment, which was a blend of the statewide mean/standard costs developed by looking at the resources consumed by the industry as a whole and the hospital-specific resources and costs consumed in treating particular illnesses, categorized as diagnosis related groups ("DRG"). N.J.A.C. 8:31B-5.1. Each DRG reflected a wide variety of both direct and indirect patient care costs. N.J.A.C. 8:31B-3.4. These costs were derived from actual costs incurred by all acute care hospitals during a particular base year, as updated for inflation and certain other factors. N.J.A.C. 8:31B-2.5.[4] The quantification of these costs into certain "financial elements" were used to develop each hospital's "preliminary cost base" and schedule of rates. N.J.A.C. 8:31B-3.16.

The "preliminary cost base" was defined as that portion of a hospital's actual, current costs which may reasonably be required to be reimbursed to a properly utilized hospital for the efficient and effective delivery of appropriate and necessary health care services of high quality required by such hospital's mix of patients. N.J.S.A. 26:2H-2.k (1992). (Resp. A-11). Each hospital received a blend of its own costs and the mean/standard costs developed by looking at the hospital industry as a whole. N.J.A.C. 8:31B-3.5. Direct patient care costs in excess of the blend of the hospital's own costs and the mean/standard costs were "disincentives" which were excluded from a hospital's rates. Where, however, a hospital's costs were below the standard, the hospital nevertheless

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4. In employing a DRG-based methodology, New Jersey's hospital rate-setting system was similar to the hospital reimbursement system employed by the Medicare program. Indeed, Medicare's DRG-based methodology was developed as a result of a review of demonstration projects employing this methodology undertaken by the States of New Jersey and New York under the authority of the Secretary of the U.S. Department of Health and Human Services. *See* H.R. Rep. No. 25, 98th Cong., 1st Sess. 145, *reprinted in* 1983 U.S. Code Cong. & Ad. News 143, 364.

received a proportion of the standard costs, thereby gaining an increase or "incentive" in its rates. N.J.A.C. 8:31B-3.23(a).

The prospective nature of the rate-setting system and its reliance on illness-related diagnosis related groups precluded the establishment of rates that relied on a particular individual's length of stay, treatment and consumption of resources. For example, if a patient was admitted for an appendectomy, a hospital could only charge the patient the amount approved for the DRG classification of appendectomy, and not the actual cost of all services provided to the patient. Thus, the amount approved for a DRG classification could actually be lower or higher than the actual cost of the services that the patient received.

Each hospital's schedule of rates, defined as the amount which each hospital was permitted to charge per DRG, was approved by New Jersey's Hospital Rate Setting Commission ("HRSC"), at a level sufficient to generate the amount of revenue required to cover the revenue requirements of the preliminary cost base.

1. Uncompensated Care

Among the costs of doing business incurred by hospitals operating within New Jersey are costs associated with the provision of services to individuals who are unable to pay. These costs are known as uncompensated care costs, incurred as a result of a statutory requirement which specified that "access to quality health care shall not be denied to residents of the state because of their inability to pay for the care." L. 1991, c. 183, § 1. (Resp. A-24-25). Federal law similarly requires treatment of such patients. Under 42 U.S.C. § 1395dd, hospitals must treat and stabilize individuals in need of emergency care and women in active labor regardless of whether or not they can pay. In addition, a state licensure standard, N.J.A.C. 8:43G-5.2(c), specifies that hospitals "shall not deny admission to patients on the basis of their inability

to pay", while N.J.A.C. 8:43G-4.1(a)2 requires every New Jersey hospital patient be accorded the right to "treatment and medical services without discrimination based on race, age . . . ability to pay, or source of payment."

When Chapter 83 was originally enacted, uncompensated care costs which a particular hospital incurred were borne entirely by that particular hospital's patients. Each hospital factored in uncompensated care costs as a component of its rates in order to meet this cost of doing business. As a result, hospitals serving a large population of indigent patients were forced to charge significantly higher rates than hospitals providing less uncompensated care. The provision of a high proportion of uncompensated care threatened the financial stability of hospitals with high uncompensated care case loads.

New Jersey's hospital reimbursement system sought to alleviate the financial burdens imposed on hospitals through their provision of unreimbursed care by requiring the cost of providing such care to be considered in hospital rates charged to all patients. Thus, N.J.S.A. 26:2H-18.d expressly provided that the reasonable costs of hospital services to indigent patients and bad debts were mandatory financial elements of a hospital's preliminary cost base which were to be included in the rates charged to all non-federal payors. (Resp. A-20).

Monies utilized to reimburse hospitals for the provision of uncompensated care were collected through the imposition of a uniform charge which was added to each patient's hospital bill. The uniform charge amounts collected from all patients were then remitted by the hospitals to a Trust Fund. All monies remitted to the Fund were appropriated to the state Medicaid agency, which would then reimburse hospitals for the amount of uncompensated care that they actually provided.

2. The Medicare Cost Shift

Under N.J.S.A. 26:2H-18.1.c. (1992) (Resp. A-22), hospital rates were also permitted to account for adjustments that resulted from statutes and regulations affecting the delivery of health care. Such adjustments were required to take into account the effectiveness and efficiency of the health care delivery system as a whole. The federal Medicare program does not pay the same rates as were provided for under the New Jersey DRG reimbursement system, since Medicare payment rates are established under a separate federal statutory scheme. *See* 42 U.S.C. § 1395c *et seq.* Accordingly, DOH created adjustments in the rates paid by non-Medicare patients to account for the shortfall between what Medicare would pay and the New Jersey DRG rate. N.J.A.C. 8:31B-3.73. This was known as the "Medicare cost shift."

3. Payor Differentials

The HRSC was also permitted to grant differentials in payment rates to a payor or class of payors. N.J.S.A. 26:2H-18.b (1992) (Resp. A-18-19). If the HRSC granted a payor differential, it had to be supported by evidence of "quantifiable economic benefits rendered to the institution or to the health care delivery system taken as a whole." Under the authority of this provision, a differential from the DRG rate was accorded to patients who had health benefits coverage through certain payors, such as Blue Cross and Blue Shield, as a result of the financial benefits to society which are provided by the open enrollment programs offered by such payors. The differentials were allocated among patients covered by all payors other than Medicare so that a hospital received from all payors net revenue equal to its preliminary cost base.

B. ERISA Preemption

The Employee Retirement Income Security Act, popularly

known as ERISA, 29 U.S.C. § 1001, *et seq.*, was enacted in 1974. The subject of the ERISA statute is pension benefit plans and employee benefit plans. ERISA contains a preemption clause which provides that ERISA "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan" which is covered by ERISA. 29 U.S.C. § 1144(a).[5] The statute defines the term "state" to include any political subdivision, agency or instrumentality of a state, while state law was defined to include all laws, decisions, rules or regulations or other state action having the effect of law. 29 U.S.C. §§ 1144(c)(1), 1144(c)(2).

C. Decisions Below

Commencing in 1990 and continuing through the first half of 1992, over a dozen self-insured employee benefit plans ("the Plans") and a number of individual Plan participants commenced a series of civil actions (later consolidated) against the State of New Jersey and most of the state's acute care hospitals seeking an injunction against the application to them of New Jersey's hospital rate setting statute. The Plans and their participants alleged that certain provisions of the statutes and regulations applicable to hospital rate setting were preempted by ERISA, denied the Plans and their participants due process and equal protection under the New Jersey and United States Constitutions, violated the Fifth Amendment of the United States Constitution by creating a taking of property without just compensation, and created an unlawful tax and delegation of taxing authority. In particular, the Plans challenged the inclusion in hospital rates of: (1) the uncompensated care add-on; (2) the Medicare cost shift; and (3) payor differentials.

On May 27, 1992, the District Court issued an Opinion and Order which provided for the entry of a permanent injunction

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5. This provision is also referred to as Section 514(a).

against the state defendants. (Pet. A-64-95). The District Court enjoined enforcement of New Jersey's hospital rate setting statute and regulations to the extent that they allowed for the inclusion in hospital rates charged to ERISA-covered plan participants of costs attributable to the provision of uncompensated care, the Medicare cost shift and payor differentials. While the court acknowledged that no court had extended ERISA preemption to the extent of its opinion, the court found that New Jersey's hospital rate setting statute "related to" ERISA plans, even though the statute did "not mention benefit plans directly and [did] not regulate the terms and conditions of any such plans explicitly". (Pet. A-80). The court rejected the plans' constitutional claims. (Pet.A-85-92). The injunction was stayed pending appeal. (Pet. A-19).

On May 14, 1993, the Court of Appeals reversed the decision of the District Court. (Pet. A-1-61). The Court of Appeals concluded that New Jersey's hospital rate setting law constituted a generally applicable law which (1) is not intended to regulate the affairs of ERISA plans; (2) neither singles out such plans for special treatment nor predicates rights or obligations on the existence of an ERISA plan; and (3) does not have the effect of either dictating or restricting the manner in which ERISA plans structure or conduct their affairs or impairing their ability to operate simultaneously in more than one state. The Court of Appeals expressed an unwillingness "to attribute to Congress and Section 514 an intent to frustrate the efforts of the State, under its police power, to regulate health care costs." The court concluded that it had found no case that had held a law fitting the characteristics of the New Jersey hospital rate setting statute to be preempted by ERISA, and it would decline to so hold. (Pet. A-30).

The Third Circuit also soundly rejected the Plans' claims that the challenged costs did not constitute an unlawful taking of property without just compensation and affirmed the District Court's summary judgment for the defendants as to the Plans'

constitutional claims.[6] (Pet. A-22-23).

REASONS FOR DENYING THE WRIT

I.

REVIEW BY THIS COURT IS NOT AVAILABLE BECAUSE THE COURT OF APPEALS HAS NOT DECIDED A FEDERAL QUESTION IN A WAY THAT CONFLICTS WITH APPLICABLE DECISIONS OF THIS COURT.

Under Rule 10.1(c) of the Rules of the Supreme Court, a Petition for a Writ of Certiorari may be granted if a United States Court of Appeals has decided a federal question in a way that conflicts with applicable decisions of this Court. No such conflict has occurred as a result of the Third Circuit's decision in *United Wire*. Petitioners' efforts to convince this Court otherwise misconstrues the Court's earlier, consistent holdings that only state statutes which impact on ERISA benefit plans, not plan benefits or plan beneficiaries, are subject to preemption by ERISA.

Under ERISA preemption analysis, a law "relates to" an employee benefit plan if it has a connection with or reference to such a plan. *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 96-97 (1983). A state law that either directly or indirectly refers to, or otherwise attempts to or succeeds in regulating or interfering in the administration of employee benefit plans, relates to ERISA and is preempted. *Fort Halifax Packing Company, Inc. v. Coyne*, 482 U.S. 1, 7-8 (1987). As recently as last term, however, this Court reiterated that preemption does not occur if a state law has only a "tenuous, remote or peripheral connection with covered plans, . . . as is the case with many laws of general applicability." *District of*

6. Petitioners' equal protection, due process and tax law claims were neither raised nor considered on appeal.

Columbia v. Greater Washington Board of Trade, 113 S. Ct. 580, 583 n. 1 (1992). *See also Ingersoll- Rand v. McClendon,* 498 U.S. 133, 139 (1990); *Shaw,* 463 U.S. at 100, n. 21.

Under the plain language of the statute and this Court's precedents, there *must* be a nexus between the ERISA-covered plan and the state statute, regulation or cause of action being challenged. In the absence of such a nexus, there can be no finding of ERISA preemption. For example, in *Fort Halifax,* this Court declined to find preemption of a Maine statute requiring employers to provide a one-time severance payment to employees in the event of a plant closing. As the Court noted, a crucial feature of ERISA's preemption provision is its deliberate use of the term "employee benefit plan." While the appellants in *Fort Halifax* argued that any state law pertaining to an employee benefit listed in ERISA necessarily regulates an employee benefit plan, the Court rejected this distinction, finding the choice of words employed by Congress to be deliberate:

> Nothing in our case law, however, supports appellant's position that the word "plan" should in effect be read out of the statute . . . The words "benefit" and "plan" are used separately throughout ERISA, and nowhere in the statute are they treated as the equivalent of one another. Given the basic difference between a "benefit" and a "plan", Congress' choice of language is significant in its preemption of only the latter.

Fort Halifax, 482 U.S. at 8. Similarly, in *Mackey v. Lanier Collection Agency,* 486 U.S. 825 (1988), this Court refused to find George's general garnishment statute to be preempted, even though the statute at issue prevented plan participants from receiving their benefits and even though complying with garnishment orders might burden the administration of the plan.

In *Ingersoll-Rand Company v. McClendon,* 498 U.S. 133 (1990), this Court considered a state cause of action which allowed former employees to bring wrongful discharge suits based upon the fact that the alleged reason for discharge was a desire not to make payments to the employee out of an employee benefit plan. Although the Court concluded that the state cause of action was preempted by ERISA, the Court nevertheless reiterated that there are limits to ERISA preemption. The Court reaffirmed its earlier determination in *Fort Halifax* that under the plain language of the ERISA statute, only state laws that relate to benefit *plans* are preempted. *Ingersoll-Rand,* 498 U.S. at 139. The Court also noted that under its decision in *Mackey,* the fact that collection might burden the administration of a plan did not, by itself, compel preemption. In finding that the state cause of action considered in *Ingersoll-Rand* was preempted by ERISA, the Court drew the following distinction between laws that are preempted by ERISA and those that are not:

> We are not dealing here with a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan, nor is the cost of defending this lawsuit a mere administrative burden. Here, the existence of a pension plan is a critical factor in establishing liability under the state's wrongful discharge law.

Id. at 139-140. Thus, the Court did not retreat from its earlier holdings that ERISA preemption is not without limits and that laws which operate irrespective of the existence of ERISA plans can survive a preemption challenge.

The Third Circuit's decision is entirely consistent with this Court's prior decisions regarding the scope of ERISA preemption. The court analyzed the impact that New Jersey's rate setting statute had on ERISA plans and concluded that the requisite nexus

between the challenged statute and the plans was lacking in this case. This was entirely appropriate, since all that New Jersey's hospital rate setting scheme did was to establish a methodology of setting hospital rates which calculated the price charged to hospital patients for the services that they received irrespective of whether or not they possessed health benefits coverage.[7] As the Third Circuit correctly found, New Jersey's hospital rate setting statute never dictated what an employee benefit plan must pay, and did not require ERISA plans to cover a plan participant's total hospital costs. Under the statutory and regulatory scheme, plans remained free to set their benefit levels without any reference to the state-regulated DRG rate, and were free to pay whatever portion of an individual's hospital bill they deemed appropriate.[8] While the rate-setting system did impact upon the price for hospital services paid by plan participants, the system did not impose any requirements on the plan itself.

Petitioners argue that there is a direct impact on the plan because of the economic impact that payment of the challenged

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7. Even individuals who were uninsured had amounts attributable to uncompensated care, the Medicare cost shift and payor differentials included in the rates they were charged by hospitals.

8. The provision of uncompensated care originates in part from federal requirements specifying that hospitals must provide indigent care. 42 U.S.C. § 1395dd mandates hospitals to treat and stabilize individuals experiencing emergency conditions (including women in active labor) irrespective of their ability to pay. In addition, regulations under the federal Hill-Burton program preclude hospitals receiving Hill-Burton funding from denying emergency services to persons residing in the facility's service area due to an inability to pay. *See* 42 C.F.R. § 124.603. The uncompensated care add-on represented a mechanism developed by the state to compensate hospitals for the costs of providing these services. It would be inconsistent to find that one federal law would preclude hospitals from recovering revenues needed to comply with the requirement that they provide uncompensated care at the same time that another federal law mandates that hospitals provide such care.

add-ons had on the plan and plan participants. This overlooks the fact that this Court has never found a statute to be preempted simply because it increases the price paid by plan participants for a particular commodity.[9]

Petitioners' analysis reflects a fundamental misunderstanding of the mechanics of setting a price for hospital services. The cost of providing uncompensated care and of discounts provided to certain payors is no different from any other type of cost that hospitals incur. As the Third Circuit accurately observed, a state's imposition of this cost of doing business is:

> No different in kind, however, from any state regulation that increases the cost of goods or services that hospitals consume and pass on in hospital costs, i.e. utility costs, the wages of its employees, waste disposal costs, etc.

(Pet. A-26). In this regard, hospitals function just like any other business, where prices established include not only operating expenses but sufficient markup to cover theft, spoilage and discounts provided to wholesale customers or during promotional events. The payment of these costs does not constitute a payment for the benefit of others, as petitioners allege, but merely represents reimbursement to the hospitals to cover their costs of doing business.

The fact that compliance with a state statute might indirectly increase plan costs was held not to be a sufficient ground for

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9. Petitioners assert that New Jersey's statute thwarted the express purpose of their plans because many plans have a purpose of paying 100% of a participant's hospital bill. While this is a laudable goal, the State cannot be required to set hospital rates at a level that will permit third party payors to cover the full amount of a patient's bill. The issue raised by petitioners is an economic issue, not an ERISA preemption issue.

preemption in this Court's earlier decision in *Mackey,* where a Georgia garnishment law was found not to be preempted by ERISA despite the fact that "substantial administrative burdens and costs" were incurred by the plans in complying the statute. *Mackey,* 486 U.S. at 831-32. Given the result in *Mackey,* the Third Circuit's conclusion that New Jersey's statute is not preempted despite the fact that it may increase the charges billed to ERISA plan participants for hospital services is entirely consistent with this Court's prior decisions in this area.

No hospital bill purports to represent the actual cost of treating a particular individual. There are many types of costs incurred by hospitals that must be passed on to their patients which do not necessarily relate to the specific resources that the particular patient consumes. For example, hospital rates include amounts attributable to capital costs incurred by hospitals for improvements to a hospital facility. If a hospital constructs a pediatrics wing, it can include some of the costs attributable to this construction and the debt service payments associated with it in its rates. Thus, a 45 year old hospitalized for knee surgery may be paying a small portion of the costs attributable to the construction of a new pediatrics wing in his rates, even though this individual would not receive any services in that wing. The Third Circuit concluded that it is impossible for hospitals to set their prices in such a way as to only provide a bill for the specific services rendered to an individual patient. (Pet.A-31). This conclusion does not conflict with any prior decision by this Court. Nothing in this Court's earlier decisions can be read as standing for the proposition that ERISA plan participants may only be required to pay those components of a price which relate specifically to identifiable goods and services actually consumed by the plan participant.

The petitioners candidly admit that they do not challenge the underlying DRG reimbursement feature of New Jersey's hospital reimbursement statute, an admission that is fraught with an inherent and obvious contradiction. Under the DRG system, a

price was set for a particular type of service irrespective of the length of time that the patient stays in the hospital. Thus, a patient hospitalized for an appendectomy would receive the same bill irrespective of whether the patient stayed in the hospital 2, 4 or 6 days, absent any complicating factors which would have justified an additional payment. Because this system is based on an average cost per case, and not the actual cost incurred by a particular patient, utilization of a DRG system means that all patients will have costs included in their hospital rates which are attributable to others. Indeed, participants in the petitioners' plans directly benefited from this system of averages if they stayed in the hospital longer than the average period of time for a particular DRG, since the DRG would be calculated based upon a review of the costs associated with the average number of days of hospitalization for that illness. The very foundation of a DRG-based system is the provision of positive and negative incentives for hospitals to reduce costs. Petitioners cannot be permitted to selectively retain the benefits of the state's efforts to make health care affordable, while avoiding any perceived burdens in participating in the system. In either case, the State's pricing structure affects the relationship between the hospital and the plan participant, not the relationship between the hospital and the plan.

Petitioners assert that they are forced to subject their plan to conflicting forms of administration and that they are forced to abide by inconsistent regulations. However, the record is devoid of any evidence that hospital rates are uniform among all other states, and that New Jersey is somehow unique. The cause of the administrative difficulties and inconsistencies referenced by petitioners does *not* flow from the peculiar features of New Jersey's hospital rate setting system, but the fact that hospital prices can vary substantially among different states, or even within different geographic regions of a particular state. Hospital rates will, of necessity, be affected by such varying factors as differences in wage costs, as well as differences in the price of purchasing the commodities used by hospitals. As the Third Circuit

noted, the petitioners would always be subject to these inherent inconsistencies, regardless of the nature of the reimbursement system utilized or the components contained therein.

The petitioners' flawed analysis also overlooks the fact that the challenged components of the DRG rate are components of hospital rates in all states, not just New Jersey. Several other states which regulate hospital rate-setting include the cost of providing uncompensated care in the rates. *See, e.g.*, N.Y.P.H.L. § 2807-c. The Third Circuit's conclusion that state regulation of hospital pricing is not likely to make interstate operation of an ERISA plan more difficult is entirely consistent with this Court's prior decisions. This Court has never held that either ERISA-covered plans or their participants must be permitted to pay the same price for a particular service in different states, even though there may be legitimate reasons for prices varying from one state to another. Hospitals which set their own rates in a non-regulated setting include costs attributable to charity care, bad debt, Medicare shortfalls and payor discounts in their rates as costs of doing business. Indeed, the District Court acknowledged this by stating that "Even if New Jersey did not enact Chapter 83, hospitals would still charge plaintiffs for uncompensated care . . . so that they could comply with their statutory obligations to provide hospital care for everyone regardless of that person's ability to pay." (Pet.A-92). It defies logic to suggest that costs which would normally be included in hospital charges in the absence of state regulation cannot be included in the rates charged to ERISA plan participants if the same costs are established pursuant to state statute. To find New Jersey's system to be preempted by ERISA would raise a serious question regarding the ability of a state to take *any* action regarding regulation of hospital rates, since the mere action of setting rates which will be paid by participants in ERISA-covered plans could arguably cause such plans to structure benefits in a particular manner.

Petitioners assert that because the statute includes a reference

to "union welfare plan identification cards", the statute expressly references ERISA plans and is therefore preempted. The reference in question simply provides that a hospital shall not be reimbursed for the cost of providing uncompensated care unless it interviews each patient admitted to determine whether the patient is covered by health insurance, as documented by such items as "a union welfare plan identification card or claim form." N.J.S.A. 26:2H-18.31. All that the statute does is require verification of whether third party insurance is available to pay all or part of a patient's bill. It does not regulate the amount of coverage or set the rate that must be paid, and does not impose any additional burdens upon plan administrators. In short, this provision causes no impact on the plan at all, whether direct or indirect. Thus, as the Third Circuit correctly found, this reference should be regarded as without legal consequence for preemption purposes, and is therefore distinguishable from the references contained in the statutes analyzed by this Court in its *FMC* and *District of Columbia* decisions.[10]

Petitioners also contend that their participants derived no benefit from the existence of the challenged components in New Jersey's hospital rates and that their participants bore a disproportionate share of the burden in covering these costs. It is not true that plan participants derived no benefit from inclusion of these costs in hospital rates. Without coverage of these legitimate business costs, hospitals could not survive. Therefore, plan participants did derive a direct benefit from these costs because payment of these costs helped to provide hospitals with sufficient cash flow to keep their doors open.

New Jersey's hospital rate setting statute did place a large

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10. The references to self-funded union plans in the Department of Health's Patient Appeal Policy also should not result in a finding of preemption. The Patient Appeal Policy does not regulate the plans or the rates they are charged, or cause any impact on the plan administrator.

share of the burden of paying for uncompensated care upon individuals who have the resources to pay for such care. However, while the fact that individuals who pay for hospital services bear a larger share of the overall cost of providing such services may be unfair or debatable from a social policy point of view, this does not give rise to a violation of ERISA. Plainly, ERISA does not address the rights of plan participants as consumers. As this Court has repeatedly held, the only impact the ERISA preemption provision is concerned with is the impact that a statute or a state cause of action has on the plan itself. The Third Circuit's decision is, therefore, in full accord with this Court's prior decisions respecting ERISA preemption, since the Third Circuit concluded that any impact on the plan itself, a necessary prerequisite to a finding of ERISA preemption, was absent here.

II.

THE THIRD CIRUIT'S DECISION IS NOT IN CONFLICT WITH THE DECISION OF ANOTHER UNITED STATES COURT OF APPEALS.

Under Supreme Court Rule 10.1(a), this Court may exercise its discretion and grant a Petition for a Writ of Certiorari when a United States Court of Appeals has rendered a decision in conflict with the decision of another United States Court of Appeals on the same matter. The requisite conflict between the Circuits is lacking in this case. The only Court of Appeals decision to address an issue similar to those present in this case was *Rebaldo v. Cuomo*, 749 F.2d 133 (2nd Cir. 1984), a case whose reasoning was followed by the Third Circuit in reaching its decision in *United Wire*. While petitioners may seek to characterize other cases as being in conflict with the decision of the Third Circuit, these cases are either trial court decisions or deal with different issues and, therefore, do not create a direct conflict.

Rebaldo is the only Court of Appeals decision which deals

with the issue of ERISA preemption in the context of a review of a hospital rate setting statute. The statute at issue in *Rebaldo* prohibited hospitals from establishing inpatient charges for self-insured employee benefit plans that were different than the charges authorized by a state statute. The Second Circuit sustained the New York statute against an ERISA preemption challenge. The Second Circuit's decision in *Rebaldo* was premised upon two findings: (1) that a state statute cannot be found to be preempted by ERISA unless it "purports to regulate the terms and conditions of an employee benefit plan" and (2) that a state statute which constitutes a generally applicable exercise of a state's police powers should not be found preempted by ERISA if it only affects a plan in a tenuous, peripheral or remote manner. The Third Circuit followed the second prong of the *Rebaldo* court's analysis. Thus, there is uniformity among the circuits with respect to the issue of whether a generally applicable hospital rate-setting statute should be viewed as preempted by ERISA.

Petitioners attempt to gloss over the fact that no conflict between the circuits is present here by arguing that the decision in *Rebaldo* has been effectively overruled by subsequent decisions of this Court and other lower courts. *Rebaldo* and *United Wire* are the only circuit court decisions dealing specifically with the issue of whether a generally applicable hospital rate setting statute is preempted by ERISA. Even if it were assumed for the sake of argument that *Rebaldo* was no longer good law, all that this would mean is that *United Wire* would stand on its own as the only Court of Appeals decision dealing with this particular issue. Thus, the requisite conflict between the circuits would still be lacking.

Moreover, the portion of the *Rebaldo* decision upon which the Third Circuit relied has not been overruled. The *Rebaldo* court's first rationale for finding no preemption has been narrowed by this Court's decision in *Ingersoll-Rand,* which held that a state cause of action which was predicated on the existence of an employee benefit plan could be preempted even if it did not purport to

regulate the terms and conditions of ERISA plans. However, the Supreme Court has not overruled the second and more important prong of the Second Circuit's analysis in *Rebaldo*. The state cause of action at issue in *Ingersoll-Rand* was not a generally applicable law which functioned irrespective of the existence of an ERISA plan. Indeed, both in *Ingersoll-Rand* and the more recent *District of Columbia* decision, this Court was careful to make an express note of the fact that it was *not* dealing with a generally applicable statute which affected a plan in a "tenuous, remote or peripheral" manner. Thus, *Rebaldo* has not been overruled by subsequent decisions of this Court.

The portion of the *Rebaldo* holding relied on by the Third Circuit has also never been overruled by the Second Circuit. In *Aetna Life Insurance Company v. Borges*, 869 F.2d 142 (2nd Cir. 1989), *cert. denied*, 493 U.S. 811 (1989), the Second Circuit reaffirmed this portion of its *Rebaldo* holding. While there is a footnote in the Second Circuit's decision in *Smith v. Dunham- Bush Inc.*, 959 F.2d 6, 9 n.3 (2nd Cir. 1992) referencing *Rebaldo*, the Court noted only that *Rebaldo* could no longer be invoked for the proposition that a state law is preempted "only if it relates to and *purports to regulate an ERISA plan*." (Emphasis in original). However, the court in *Smith* never addressed *Rebaldo's* holding that a generally applicable state law cannot be preempted if its relationship with an ERISA plan is too tenuous, remote or peripheral to satisfy the "relate to" test.

Petitioners attempt to create a conflict between the circuits where none exist by arguing that several courts have found state laws to be preempted even where they can be categorized as generally applicable state laws involving an exercise of the state's police powers. These cases do not involve an exercise of the state's police power to regulate health care matters, and while the statutes analyzed in these other cases were generally applicable exercises of the state's police power, they had a concrete and direct impact on the plan. Thus, the decisions in these cases have not overruled the

portion of the *Rebaldo* decision relied on by the Third Circuit, and do not create a conflict either with *Rebaldo* or with the Third Circuit's decision in *United Wire*.

For example, in *General Electric v. Department of Labor*, 891 F.2d 25 (2d Cir. 1989), the Second Circuit held that a state law which required an employer to either bring the cost of its prescribed benefits into equivalence with the cost of local prevailing benefits or to pay the additional cost directly to employees was preempted by ERISA. However, while a labor law could be characterized as a generally applicable exercise of the state's police powers, the majority opinion in *General Electric* did not analyze the statute's status as such a law. Moreover, the law's affect on the plan was neither tenuous nor remote, because the plan was specifically told that it either had to pay benefits or maintain detailed records showing that another form of equivalent compensation was provided. In contrast, New Jersey's hospital rate setting system neither required plans to provide a particular level of benefits nor required a plan to establish how its participants' health care costs are otherwise being paid for.

In *Arkansas Blue Cross and Blue Shield v. St. Mary's Hospital*, 947 F.2d 1341 (8th Cir. 1991), *cert. denied*, 112 S. Ct. 2305 (1992), the Eighth Circuit held that an Arkansas statute that allowed a plan participant to assign benefits to health care providers, thus forcing plans to honor all assignments of benefits made by plan participants, was preempted by ERISA. While the court stated in its opinion that a state law's relationship to traditional state authority was not relevant to the question of whether a state statute relates to ERISA plans, the court went on to determine that this factor "is a policy consideration useful in deciding borderline questions of ERISA preemption," and analyzed the state statute at issue by reviewing the state's interest in enforcing it. *Arkansas Blue Cross*, 947 F.2d at 1350. Moreover, unlike the statute at issue in this case, the statute analyzed in *Arkansas Blue Cross* directed

plan administrators where benefits could be paid. This was a direct requirement imposed on the plans, and thus clearly could not be said to impact plans in a tenuous or remote manner.

The Eighth Circuit relied on *Gilbert v. Burlington Industries, Inc.*, 765 F.2d 320, 327 (2nd Cir. 1985) and *Boise Cascade Corporation v. Peterson*, 939 F.2d 632 (8th Cir. 1991) as authority for its conclusion in the *Arkansas Blue Cross* case regarding ERISA preemption. In both of these cases, however, the courts found that in order to avoid preemption, a statute representing the exercise of a traditional police power must *also* affect a plan in only a tenuous, remote or peripheral manner. *Gilbert*, 765 F.2d at 327, *Boise Cascade*, 939 F.2d at 639. This is the same reasoning utilized by the *Rebaldo* court. These cases similarly cannot be relied on as authority for the proposition that a conflict in the circuits exists regarding *Rebaldo's* enduring premise.[11]

Petitioners also rely on several lower court decisions where a generally applicable hospital rate setting law was found preempted and argue that a conflict is created by the existence of these decisions. First of all, the existence of these cases does not warrant further review by this Court, since this Court's rules do not permit the Court to exercise its discretion and grant a Petition for a Writ of Certiorari when there is a conflict between a Court of Appeals and a

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11. Petitioners also reference *Bricklayers Local No. 1 v. Louisiana Health Insurance*, 771 F. Supp. 771 (S.D. La. 1991), a District Court case. There, a Louisiana statute required plans to pay a $2 service charge as part of an individual's hospital bill. The funds were utilized to fund a catastrophic health insurance program. The Louisiana statute made the patient's insurance arrangement directly responsible for payment of the service charges and further required that payment of these charges had to be a "mandated benefit covered by an individual's insurance plan." The District Court decided that the statute was preempted. The Louisiana statute did not affect the plans in a tenuous or peripheral manner, since the service charge was levied directly on the plan, and the plan had no discretion as to whether to pay it or not.

lower court. Secondly, the analysis employed to strike down the hospital rate setting statutes at issue in each of these cases is seriously flawed.

In *Traveler's Insurance Company v. Cuomo*, 813 F. Supp. 996 (S.D.N.Y. 1993), *appeal pending*, No. 93-7194 (2nd Cir.), a federal District Court in New York invalidated certain aspects of New York's hospital rate setting scheme on ERISA preemption grounds and expressly stated that it would not follow *Rebaldo*. However, the District Court's decision in that case relied heavily on the decision of the District Court in the within matter, which was subsequently reversed by the Third Circuit. Petitioners also reference the state trial court decision in *United Health Services, Inc. v. Upstate Administrative Services*, 573 N.Y.S. 2d 851 (Sup. Ct. Broome Cty. 1991). The reasoning in *United Health* was based on a flawed premise. The court concluded that plan administrators were subjected to conflicting state regulations by virtue of the challenged statutory provision, since a plan which limited payment to the reimbursement of "actual expenses" would provide a different percentage level of coverage in New York than in a state that did not set reimbursement rates as New York did. This analysis presupposed that hospital rates in all states would have to be set in an identical manner in order to withstand scrutiny under ERISA, and overlooks the fact that things such as wage rates, material costs and the costs of doing business can differ dramatically in different parts of the United States.

Because there is no conflict between the circuits as to the portion of the *Rebaldo* holding relied on by the Third Circuit, and because this portion of the *Rebaldo* court's decision has not been overruled, it is clear that petitioners cannot demonstrate the existence of a conflict between the circuits which would justify the grant of their petition for a Writ of Certiorari.

III.

THE THIRD CIRCUIT'S DISPOSITION OF THE NYSA-ILA WELFARE FUND'S TAKINGS CLAIM IS IN FULL CONFORMITY WITH STANDARDS PREVIOUSLY DELINEATED BY THIS COURT.

Both the District Court and the Court of Appeals concluded that the inclusion of certain costs in the state regulated rates charged by New Jersey hospitals did not deprive petitioners of their property without just compensation in violation of the Fifth Amendment. Petitioner NYSA-ILA Welfare Fund has sought Supreme Court review of the lower courts' disposition of this issue. Since the lower courts decided this issue in conformity with existing Supreme Court precedent, there is no conflict between the Third Circuit's decision and existing decisions of this Court. In addition, there is no Court of Appeals decision which conflicts with the Third Circuit's resolution of this issue, and it does not raise an important question of federal law which has not previously been addressed by this Court. Therefore, no further review by this Court is available.

N.J.S.A. 26:2H-18.d (1992) provided that the reasonable cost of hospital services to indigent patients, as well as bad debts, were to be included as mandatory financial elements of a hospital's preliminary cost base. (Resp. A-20-21). Clearly, the inclusion of such costs in hospital rates does not amount to a physical taking of property. As a result, a less stringent "regulatory takings" analysis, rather than a per se takings analysis, applies to the statutes and regulations being challenged by petitioners. *Concrete Pipe and Products v. Construction Laborers Pension Trust,* 113 S. Ct. 2264, 2290 (1993).

This Court has held that the takings clause is not violated simply because legislation requires one person to use his or her assets for the benefit of another. *Connolly v. Pension Benefit*

Guaranty Corp., 475 U.S. 211, 223 (1986). Moreover, requiring money to be spent in a particular way does not constitute a taking. *See United States v. Sperry Corporation*, 493 U.S. 52 (1989); *Atlas Corp. v. United States*, 895 F.2d 745, 756 (Fed. Cir. 1990), *cert. denied*, 498 U.S. 811 (1990). Evaluation of whether governmental regulation of property constitutes a taking requires an ad hoc factual inquiry into the circumstances of each case. *Connolly*, 475 U.S. at 224. This Court has identified three factors which are to be analyzed in making such a determination. These are: (1) the character of the governmental action; (2) the economic impact of the regulation on the claimant; and (3) the extent to which the regulation has interfered with distinct investment-backed expectations. *Penn Central Transportation Company v. New York City*, 438 U.S. 104, 124 (1978).

The nature of the challenged governmental action here is the inclusion of uncompensated care costs and the costs of the Medicare shortfall and payor differentials in the hospital bills given to all patients. In order to enable hospitals to remain in operation and to provide care to all in need of hospital services, the state reasonably determined that the costs of this care should be spread among all hospital patients. As a result, the Third Circuit concluded that New Jersey's rate system merely "adjusts the benefits and burdens of economic life to promote the common good," a factor which militates against the finding that a taking has occurred. *Concrete Pipe*, 113 S. Ct. at 2290, *quoting Connolly*, 475 U.S. at 225.

Petitioner asserts that a taking occurred because the uncompensated care add-ons paid by ERISA plan participants were paid into a fund managed and controlled by a state bureaucracy. The utilization of this mechanism by the state plainly does not result in the permanent appropriation of private assets. The trust fund mechanism referred to was merely a conduit utilized to fairly distribute collected uncompensated care monies to

hospitals.[12] These monies were not retained by the state. Monies attributable to the Medicare cost shift and payor differentials went directly to hospitals as a component of their hospital rates, and therefore cannot be considered to be appropriated by the state for its own use.

As both the District Court and the Court of Appeals found, plan participants received a clear, specific economic benefit from New Jersey's hospital rate setting system. Therefore, the system's economic impact on them is not so severe as to justify a finding that a taking has occurred. The amount of money paid by plan participants is not determined on an ad hoc basis, since amounts attributable to uncompensated care, the Medicare cost shift and payor differentials were directly related to an individual plan participant's hospital bill. Even in the absence of state regulation of hospital costs, hospitals would have to recoup these costs, because they would go out of business if they failed to do so. By ensuring the recovery of such costs and enabling hospitals to stay in business, New Jersey's hospital rate setting scheme thus protected the interests of ERISA plan participants (and users of hospital services generally) in maintaining access to health care. In addition, to the extent that individual plan participants might not have sufficient assets to pay their full hospital bill, the inclusion of the costs attributable to bad debts within hospital rates would have resulted in coverage of a portion of their bills.

Because hospital rate setting has long been heavily regulated on both the federal and state levels due to its technical complexity, the District Court and Court of Appeals were correct in finding that New Jersey's hospital rate setting statute did not interfere with "reasonable investment-backed expectations." As this Court has

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12. Petitioner's oblique reference to the state's use of the trust fund mechanism as a vehicle for obtaining federal matching funds from the Medicaid program is irrelevant to a takings analysis, as such funds are clearly not private monies.

previously held, reasonable investment-backed expectations under the takings clause must amount to more than a "unilateral expectation." *Webb's Fabulous Pharmacies v. Beckwith*, 449 U.S. 155, 161 (1980).

New Jersey's inclusion of uncompensated care costs and costs attributable to the Medicare cost shift and payor differentials was a long standing feature of New Jersey's state regulated hospital rate setting system. More importantly, as the District Court expressly found, if hospitals established their rates under a free market, competitive system, the challenged components could clearly be included as a portion of the hospital's overall reasonable charge. (Pet. A-92). Given the mechanics of hospital pricing, petitioners cannot reasonably assert that they have a vested right in having the hospital rates they pay exclude such costs.

Since the Third Circuit's decision conforms with prior decisions of this Court as to petitioner's takings claims, there is no valid reason for this Court to revisit the conclusions reached by the lower courts as to these claims.

IV.

THIS CASE DOES NOT PRESENT AN IMPORTANT QUESTION OF FEDERAL LAW WHICH SHOULD BE SETTLED BY THIS COURT.

Petitioners urge the Court to grant their Petitions because of the current national interest in health care reform. They also contend that the Court needs to review this case because of pending legislative initiatives in a number of states concerning hospital rate setting.

No matter how much interest may be engendered by health care issues at the moment, these circumstances clearly do not

warrant this Court's review. First of all, this case does not present a novel issue that has not previously been addressed by the Supreme Court. While the specific, narrow issue of ERISA preemption in the context of hospital rate setting has not been addressed, this Court has had occasion to review the general question of whether a state statute should be found preempted by ERISA numerous times. In deciding these cases, the Court has fashioned a test which requires that the state statute must impact upon the ERISA plan, rather than plan participants or plan benefits, in order for it to be found preempted. All that the Third Circuit did was to apply the analysis previously reached by the Court in these cases in concluding that New Jersey's hospital rate setting statute did not impact upon the plan in a manner which would require preemption.

The significance of the Third Circuit's decision has largely been eclipsed by subsequent developments in New Jersey. The State of New Jersey deregulated hospital rate setting effective January 1, 1993. *L.* 1992, c. 160. As a result, any decision the Court might reach would have no impact whatsoever on the establishment of hospital rates in New Jersey, since that function is no longer state regulated. The only remaining "live" issue between the parties relates to the question of whether plans should have to pay the full DRG rate for services rendered during the period that this litigation was ongoing. While final resolution of this issue might be important to the individual parties from a financial perspective, it clearly does not present the Court with an ongoing issue of such national importance that review by this Court is warranted.

Finally, the fact that there are pending legislative initiatives with respect to the issue of hospital rate setting in a number of states does not warrant further review by this Court. While health care reform may indeed be a pressing national issue, this court is not in the business of rendering advisory opinions. Yet this is tantamount to what petitioners are seeking when they requested review of this case because of pending state legislative initiatives.

Given the large number of federal court decisions in existence where an ERISA preemption claim was addressed, it is more than likely that this Court will have the opportunity to revisit the limits of its prior preemption decisions again in the future. Accordingly, this is not a case which presents a special or novel issue that would warrant Supreme Court review.

CONCLUSION

Because petitioners have failed to establish that they meet the requirements for the grant of a Petition for a Writ of Certiorari, it is respectfully requested that the Court deny the Petitions for a Writ of Certiorari.

Respectfully submitted,

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APPENDIX A — CORPORATE DESIGNATION OF RESPONDENTS

In accordance with Rule 29.1, respondents state that they have the following corporate parent-subsidiary relationships:

1. Atlantic City Medical Center; No parent or subsidiaries.

2. Nathan and Miriam Barnert Memorial Hospital d/b/a Barnert Hospital; No parent or subsidiaries.

3. Bayonne Hospital; No parent or subsidiaries.

4. Bayshore Community Hospital; Parent - Bayshore Health Care Services, Inc.; No subsidiaries.

5. Burdette Tomlin Memorial Hospital; Parent - Cape Health System, Inc.; No subsidiaries.

6. Chilton Memorial Hospital; Parent - Memorial Health Foundation (formerly known as Chilton Memorial Corporation); No subsidiaries.

7. Christ Hospital; Parent - Christ Hospital Health Services Corporation; No subsidiaries.

8. Clara Maass Medical Center; Parent - Clara Maass Health Systems, Inc.; No subsidiaries.

9. Community Medical Center; Parent - Community Memorial Health Services; No subsidiaries.

10. Cooper Hospital/University Medical Center; Parent - Cooper Health Care; No subsidiaries.

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11. Deborah Heart and Lung Center; No parent or subsidiaries.

12. Dover General Hospital & Medical Center; Parent - Lake Area Health System; No subsidiaries.

13. East Orange General Hospital; Parent - Essex Valley Health Care; No subsidiaries.

14. Englewood Hospital and Medical Center; Parent - Englewood Health Care Foundation, Inc.; No subsidiaries.

15. Hackensack Medical Center; Parent - Hillcrest Health Service System, Inc.; No subsidiaries.

16. Hackettstown Community Hospital; No parent or subsidiaries.

17. Helene Fuld Medical Center; Parent - Helene Fuld Healthcare; No subsidiaries.

18. Holy Name Hospital; No parent or subsidiaries.

19. Hunterdon Medical Center; Parent - Hunterdon Healthcare System, Inc.; No subsidiaries.

20. Irvington General Hospital; Parent - Beth Health Care Services Corporation; No subsidiaries.

21. Jersey Shore Medical Center; Parent - Modern Health Affiliates, Inc.; No subsidiaries.

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22. Community Hospital Group, Inc. d/b/a The JFK Medical Center; Parent - JFK Health Systems; No subsidiaries.

23. Kennedy Memorial Hospitals-University Medical Center; Parent - Kennedy Health Care Foundation; No subsidiaries.

24. William B. Kessler Memorial Hospital; No parent or subsidiaries.

25. Kimball Medical Center; Parent - Kimball Health Care Corporation; No subsidiaries.

26. The Medical Center of Ocean County, Inc.; Parent - The Ocean Health System, Inc.; No subsidiaries.

27. The Mercer Medical Center; No parent or subsidiaries.

28. Memorial Hospital of Burlington County; Parent - Memorial Health Alliance, Inc.; Subsidiary - Women's Auxiliary Board to Memorial Hospital of Burlington County.

29. Monmouth Medical Center; Parent - Mid-Atlantic Health Group, Inc.; No subsidiaries.

30. Morristown Memorial Hospital; Parent - Memorial Health Foundation, Inc.; No subsidiaries.

31. The Mountainside Hospital; Parent - Mountainside Hospital Healthcare, Inc.; No subsidiaries.

32. Muhlenberg Regional Medical Center; Parent - The Huntington Foundation; Subsidiaries - Muhlenberg Auxiliary, Inc.; and Muhlenberg Foundation, Inc.

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33. Newark Beth Israel Medical Center; Parent - Beth Health Care Services Corporation; No subsidiaries.

34. New Jersey Hospital Association; No parent or subsidiaries.

35. Newton Memorial Hospital; Parent - North Jersey Health Care Corp.; No subsidiaries.

36. The Hospital Center at Orange; No Parent; Subsidiaries - HCO Plus; Meals on Wheels; Orange Mountain Health Care; OMH Services; Zorah; and 323 Central Avenue.

37. Our Lady of Lourdes Medical Center; Parent - Our Lady of Lourdes Health Care Services, Inc.; Subsidiaries - Osborne Family Health Center, Inc.; and Our Lady of Lourdes School of Nursing.

38. Overlook Hospital; No parent or subsidiaries.

39. Palisades General Hospital; No parent or subsidiaries.

40. Pascack Valley Hospital; Parent - Well Care Group, Inc.; No subsidiaries.

41. The General Hospital Center of Passaic; Parent - Healthcare Continuum, Inc.; No subsidiaries.

42. The Medical Center at Princeton; No parent or subsidiaries.

43. Rahway Hospital; Parent - Recovery Healthsystems, Inc.; No subsidiaries.

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44. Raritan Bay Medical Center; Parent - Raritan Bay Health Service Corporation; No subsidiaries.

45. Riverview Medical Center; Parent - Riverview Health Care

46. Robert Wood Johnson University Hospital; Parent - RWJ Healthcare Corporation; No subsidiaries.

47. Kennedy Memorial Hospitals at Saddle Brook, Inc.; Parent - Kessler Rehabilitation Corporation; No subsidiaries.

48. Shore Memorial Hospital; Parent - Shore Memorial Health Foundation, Inc.; No subsidiaries.

49. Somerset Medical Center; Parent - Somerset Health Care Corporation; No subsidiaries.

50. South Amboy Memorial Hospital; Parent - South Amboy Memorial Hospital Association; No subsidiaries.

51. South Jersey Hospital System; Parent - Cooperative Health Care of Southern New Jersey, Inc.; Subsidiary - Community Health Care, Inc.

52. St. Barnabas Medical Center; Parent - St. Barnabas Corporation; No subsidiaries.

53. St. Clare's/Riverside Medical Center; Parent - SSM Healthcare Ministry Corporation; No subsidiaries.

54. St. Elizabeth Hospital; No parent or subsidiaries.

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55. St. Francis Hospital; Parent - Franciscan Health System of New Jersey, Inc.; No subsidiaries.

56. St. James Hospital; Parent - Cathedral Health Services, Inc.; No subsidiaries.

57. St. Joseph's Hospital & Medical Center; No parent or subsidiaries.

58. St. Mary Hospital; Parent - Franciscan Health System of New Jersey, Inc.; No subsidiaries.

59. St. Michael's Medical Center; Parent - Cathedral Health Services, Inc.; No subsidiaries.

60. St. Peter's Medical Center; No parent or subsidiaries.

61. Union Hospital; Parent - Mega Source, Inc.; No subsidiaries.

62. United Hospitals Medical Center; No parent or subsidiaries.

63. Underwood-Memorial Hospital; Parent - Underwood-Memorial Health Systems, Inc.; No subsidiaries.

64. The Valley Hospital; Parent - Valley Care Corp.; Subsidiary - Valley Health Services, Inc.

65. Wallkill Valley Hospital & Health Centers; Parent - Sisters of Sorrowful Mothers; No subsidiaries.

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66. Warren Hospital; Parent - Warren Hospital Health Services Corporation; No subsidiaries.

67. Wayne General Hospital; Parent - North Jersey Meditech; No subsidiaries.

68. West Hudson Hospital; Parent - Trico Health Care, Inc.; No subsidiaries.

69. West Jersey Hospital; Parent - West Jersey Health System; No subsidiaries.

70. Zurbrugg Memorial Hospital; Parent - Zurbrugg Health Foundation; No subsidiaries.

APPENDIX B — STATUTES REFERENCED

N.J.S.A. 26:2H-1

26:2H-1. Declaration of policy

It is hereby declared to be the public policy of the State that hospital and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health. In order to provide for the protection and promotion of the health of the inhabitants of the State, promote the financial solvency of hospitals and similar health care facilities and contain the rising cost of health care services, the State Department of Health, which has been designated as the sole agency in this State for comprehensive health planning under the "National Health Planning and Resources Development Act of 1974" (Federal Law 93-641),[1] as amended and supplemented, shall have the central, comprehensive responsibility for the development and administration of the State's policy with respect to health planning, hospital and related health care services and health care facility cost containment programs, and all public and private institutions, whether State, county, municipal, incorporated or not incorporated serving principally as residential health care facilities, nursing or maternity homes or as facilities for the prevention, diagnosis, or treatment of human disease, pain, injury, deformity or physical condition, shall be subject to the provisions of this act.

N.J.S.A. 26:2H-2

26:2H-2. Definitions

The following words or phrases, as used in this act, shall have the following meanings, unless the context otherwise requires:

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1. 42 U.S.C.A. § 300k et seq.

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a. "Health care facility" means the facility or institution whether public or private, engaged principally in providing services for health maintenance organizations, diagnosis of treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, outpatient clinic, dispensary, home health care agency, residential health care facility and bioanalytical laboratory (except as specifically excluded hereunder) or central services facility serving one or more such institutions but excluding institutions that provide healing solely by prayer and excluding such bioanalytical laboratories as are independently owned and operated, and are not owned, operated, managed or controlled, in whole or in part, directly or indirectly by any one or more health care facilities, and the predominant source of business of which is not by contract with health care facilities within the State of New Jersey and which solicit or accept specimens and operate predominantly in interstate commerce.

b. "Health care service" means the preadmission, outpatient, inpatient and postdischarge care provided in or by a health care facility, and such other items or services as are necessary for such care, which are provided by or under the supervision of a physician for the purpose of health maintenance organizations, diagnosis or treatment of human disease, pain, injury, disability, deformity or physical condition, including, but not limited to, nursing service, home care nursing and other paramedical service, ambulance service, service provided by an intern, resident in training or physician whose compensation is provided through agreement with a health care facility, laboratory service, medical social

service, drugs, biologicals, supplies, appliances, equipment, bed and board, but excluding services provided by a physician in his private practice or by practitioners of healing solely by prayer, and services provided first aid rescue and ambulance squads as defined in the "New Jersey Safety Highway Act of 1971," P.L. 1971, c. 351 (C. 27:5F-1 et seq.).

c. "Construction" means the erection, building, or substantial acquisition, alteration, reconstruction, improvement, renovation, extension or modification of a health care facility, including its equipment, the inspection and supervision thereof; and the studies, surveys, designs, plans, working drawings, specifications, procedures, and other actions necessary thereto.

d. "Board" means the Health Care Administration Board established pursuant to this act.

e. "Commission" means the Hospital Rate Setting Commission established pursuant to this act.

f. "Government agency" means a department, board, bureau, division, office, agency, public benefit or other corporation, or any other unit, however described, of the State or political subdivision thereof.

g. "Statewide Health Coordinating Council" means the Statewide Health Coordinating Council formed under the provisions of Federal Law 93-641, as amended and supplemented.[1]

h. "Health Systems Agency" means an officially recognized health systems agency formed under the provisions of Federal law 93-641 as amended and supplemented.[2]

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1. 42 U.S.C. A. § 300k et seq.

2. 42 U.S.C.A. § 300*l*-1

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i. "Department" means the State Department of Health.

j. "Commissioner" means the State Commissioner of Health.

k. "Preliminary cost base" means that proportion of a hospital's current cost which may reasonably be required to be reimbursed to a properly utilized hospital for the efficient and effective delivery of appropriate and necessary health care services of high quality required by such hospital's mix of patients. The preliminary cost base initially may include costs identified by the commissioner and approved or adjusted by the commission as being in excess of that proportion of a hospital's current costs identified above, which excess costs shall be eliminated in a timely and reasonable manner prior to certification of the revenue base. The preliminary cost base shall be established in accordance with regulations proposed by the commissioner and approved by the board.

l. "Certified revenue base" means the preliminary cost base adjusted by the commission, as appropriate and necessary pursuant to regulations proposed by the commissioner and approved by the board, to provide for the financial solvency of a hospital which is properly utilized and which delivers, effectively and efficiently, appropriate and necessary health care services of a high quality required by its mix of patients.

m. "Provider of health care" means an individual (1) who is a direct provided of health care service in that the individual's primary activity is the provision of health care services to individuals or the administration of health care facilities in which such care is provided and, when required by State law, the individual has received professional training in the provision of such services or in such administration and is licensed or certified

for such provision or administration; or (2) who is an indirect provider of health care in that the individual (a) holds a fiduciary position with, or has a fiduciary interest in, any entity described in subparagraph b(ii) or subparagraph b(iv); provided, however, that a member of the governing body of a county or any elected official shall not be deemed to be a provider of health care unless he is a member of the board of trustees of a health care facility or a member of a board, committee or body with authority similar to that of a board of trustees, or unless he participates in the direct administration of a health care facility; or (b) received, either directly or through his spouse, more than one-tenth of his gross annual income for any one or more of the following:

(i) Fees or other compensation for research into or instruction in the provision of health care services;

(ii) Entities engaged in the provision of health care services or in research or instruction in the provision of health care services;

(iii) Producing or supplying drugs or other articles for individuals or entities for use in the provision of or in research into or instruction in the provision of health care services;

(iv) Entities engaged in producing drugs or such other articles.

n. "Private long-term health care facility" means a nursing home, skilled nursing home or intermediate care facility presently in operation and licensed as such prior to the adoption of the 1967 Life Safety Code by the State Department of Health in 1972 and which has a maximum 50-bed capacity and which does not accommodate Medicare or Medicaid patients.

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N.J.S.A. 26:2H-4.1

26:2H-4.1. Hospital rate setting commission

a. There is hereby established in the State Department of Health a Hospital Rate Setting Commission which shall consist of five members, three of whom shall be appointed by the Governor with the advice and consent of the Senate for terms of 4 years. Of the initial appointees, one shall serve for a term of 2 years and one for a term of 3 years. No member shall be eligible for appointment for more than two full consecutive terms. Two of the members appointed by the Governor shall be consumers of health care services who are not providers of health care services, and one shall have experience in hospital administration or finance. The Commissioners of the State Departments of Health and Insurance or their designated representatives, who shall be officials with the rank of deputy or assistant commissioner, shall serve as ex-officio voting members of the commission. The commission shall annually select a chairman from among its members. Three members of the commission shall constitute a quorum and no action of the commission shall be taken except upon the affirmative vote of a majority of its members.

The appointed members of the commission shall each receive compensation at $150.00 per day. The commission members shall also be entitled to reasonable expenses incurred in the performance of their duties. Any such member may be removed from office by the Governor, for good cause shown. Any vacancy occurring in the membership of the commission for any cause shall be filled in the same manner as the original appointment but for the unexpired term only. A member shall otherwise continue to serve after expiration of his term until a new appointment is made.

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The commission shall select an executive secretary and the commissioner shall provide to the commission such clerical staff, supplies and equipment as may be necessary for it to faithfully discharge its duties.

The commission shall be established and its members appointed by January 1, 1979.

b. The commissioner shall determine the order in which hospitals shall have their preliminary cost base and appropriate schedule of rates approved by the commission. The commissioner shall propose and the commission approve or adjust the preliminary cost base, and the commission shall approve an appropriate schedule of rates for all hospitals by January 1, 1983. The schedule of rates shall be reasonable and sufficient to provide the revenue requirements of the preliminary cost base and shall be adjusted from time to time, as appropriate, to reach the certified revenue base.

The commission shall certify the revenue base, provided the conditions described in subsections k. and *l.* of section 2 of this act has been met, and shall perform such other duties as are specified elsewhere in this act.

A hospital shall continue to be reimbursed under the rate setting system in effect on the day preceding the effective date of this act, except as said system is amended by regulation, until the commission approves the hospital's preliminary cost base.

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N.J.S.A. 26:2H-5

26:2H-5. Powers of commissioner

a. The commissioner, to effectuate the provisions and purposes of this act, shall have the power to inquire into health care services and the operation of health care facilities and to conduct periodic inspections of such facilities with respect to the fitness and adequacy of the premises, equipment, personnel, rules and bylaws and the adequacy of financial resources and sources of future revenues.

b. The commissioner, with the approval of the board, shall adopt and amend rules and regulations in accordance with the Administrative Procedure Act, P.L. 1968, c. 410 (C. 52:14B-1 et seq.) to effectuate the provisions and purposes of this act, including but not limited to: (1) the establishment of requirements for a uniform Statewide system of reports and audit relating to the quality of health care provided, health care facility utilization and costs; (2) certification by the department of schedules of rates, payments, reimbursement, grants and other charges for health care services as provided in section 18; and (3) standards and procedures relating to the licensing of health care facilities and the institution of additional health care services.

c. The commissioner may enter into contracts with any government agency, institution of higher learning, voluntary nonprofit agency, or appropriate planning agency or council; and such entities are authorized to enter into contracts with the commissioner to effectuate the provisions and purposes of this art.

d. The commissioner may provide consultation and assistance to health care facilities in operational techniques,

including but not limited to, planning, principles of management, and standards of health care services.

e. At the request of the commissioner, health care facilities shall furnish to the Department of Health such reports and information as it may require to effectuate the provisions and purposes of this act, excluding confidential communications from patients.

f. The commissioner may institute or cause to be instituted in a court of competent jurisdiction proceedings to compel compliance with the provisions of this act or the determinations, rules, regulations and orders of the commissioner.

g. Notwithstanding any rules and regulations governing private long-term health care facilities and enforcing the 1967 Life Safety Code, as amended and supplemented, the commissioner shall permit third floor occupancy of such facilities by owners, members of their immediate families, and licensed professionals employed at such facilities.

N.J.S.A. 26:2H-12

26:2H-12. Health care facility; requirements for operation; license; application; fees; issuance; renewals

a. No health care facility shall be operated unless it shall: (1) possess a valid license issued pursuant to this act, which license shall specify the kind or kinds of health care services the facility is authorized to provide; (2) establish and maintain a uniform system of cost accounting approved by the commissioner; (3) establish and maintain a uniform system of reports and audits meeting the requirements of the commissioner; (4) prepare and review

annually a long range plan for the provision of health care services, which plan shall be compatible with the State Health Plan established pursuant to the "National Health Planning and Resources Development Act of 1974" (Federal Law 93-641)[1] as related to medical health services, health care services, and health manpower; and (5) establish and maintain a centralized, coordinated system of discharge planning which assures every patient a planned program of continuing care and which meets the requirements of the commissioner which requirements shall, where feasible, equal or exceed those standards and regulations established by the Federal Government for all federally-funded health care facilities but shall not require any person who is not in receipt of State or Federal assistance to be discharged against his will.

b. (1) Application for a license for a health care facility shall be made upon forms prescribed by the department. The department shall charge such nonrefundable fees for the filing of an application for a license and any renewal thereof, as it shall from time to time fix in rules or regulations; provided, however, that no such fee shall exceed $2,000.00. The application shall contain the name of the health care facility, the kind or kinds of health care service to be provided, the location and physical description of the institution, and such other information as the department may require. (2) A license shall be issued by the department upon its findings that the premises, equipment, personnel, including principals and management, finances, rules and bylaws, and standards of health care service are fit and adequate and there is reasonable assurance the health care facility will be operated in the manner required by this act and rules and regulations thereunder.

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1. 42 U.S.C.A. § 300K et seq.

c. A license issued before the effective date of this act to a health care facility for its operation, upon the first renewal date thereafter, may be extended for a 1 year period of time, provided the facility then meets the requirements for licensure at the time said license was issued and submits an acceptable plan to meet current requirements at the end of said period of time.

N.J.S.A. 26:2H-18

26:2H-18. Payments by government agency or hospital service corporation; determination of rates

a. No government agency and no hospital service corporation organized under the laws of the State and no other purchasers of health care services shall purchase, pay for or make reimbursement or grant-in-aid for any health care service provided by a health care facility unless at the time the service was provided, the health care facility possessed a valid license or was otherwise authorized to provide such service.

b. Payment by government agencies other than those made through the Medical Assistance and Health Services Act, P.L. 1968, c. 413 (C. 30:4D-1 et seq.), and payment by hospital service corporations organized under the laws of this State for health care services provided by a hospital shall be at reasonable rates approved by the commission as provided for by regulations proposed by the commissioner and approved by the board.

The schedule of rates shall be reasonable and sufficient to provide the revenue requirements of the certified revenue base of a hospital, considering the health care system as a whole and based on financial elements approved by the commissioner. Nothing herein shall be construed to prohibit the Commissioner of Human

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Services from contracting with the Commissioner of Health for the commission to approve rates, on behalf of the Commissioner of Health, by which hospitals are reimbursed pursuant to the Medical Assistance and Health Services Act, P.L. 1968, c. 413 (C. 30:4D-1 et seq.). Rates of payment by hospital service corporations organized under the law of this State for health care services provided by a hospital shall be set by the commission. Payment by all other purchasers of health care services provided by a hospital shall be at reasonable rates approved by the commission as provided in this act. All payment rates shall be equitable for each payor or class of payors without discrimination or individual preference except for quantifiable economic benefits rendered to the institution or to the health care delivery system taken as a whole. In addition to other such benefits which the commission may consider, it shall consider the following, if found to be quantifiable: (1) degree of promptness and volume of payments to hospitals so that hospitals are provided with funds for current financing of their services; and (2) broad provision of health insurance coverages which are not otherwise affordable or obtainable at premium rates which are not self-supporting. In determining the quantifiable economic benefits to which consideration shall be given in approving payment rates, the commission may consider overall financial benefits to society which are provided by programs offered by a payor or class of payors.

c. Payment by government agencies other than those made through the Medical Assistance and Health Services Act, P.L. 1968, c. 413 (C. 30:4D-1 et seq.), and payment by hospital service corporations organized under the laws of this State for health services provided by health care facilities other than hospitals shall be at reasonable rates set by the commissioner based on financial elements approved by him; provided, however, that nothing herein

shall be construed to prohibit the Commissioner of Human Services from contracting with the commissioner for the setting of rates by which health care facilities other than hospitals are reimbursed pursuant to the Medical Assistance and Health Services Act, P.L. 1968, c. 413 (C. 30:4D-1 et seq.). Rates of payment by hospital service corporations organized under the laws of this State for health care services provided by a health care facility other than hospitals shall be set in consultation with the Commissioner of Insurance.

d. The financial elements of the preliminary cost base and of the certified revenue base shall include the reasonable cost of the following, as defined in regulations proposed by the commissioner and approved by the board: direct patient care; principal and interest payments; paid taxes, excluding income taxes; educational, research and training programs, not otherwise paid for by the State; the provision of health care services to individuals unable to pay for them for reasons of indigency; bad debts, provided adequate recovery procedures are followed; preservation, replacement and improvement of facility and equipment subject to appropriate planning requirements; and reasonable working capital. Said financial elements may include, where applicable and appropriate, a reasonable return on investment where a hospital is operating efficiently and effectively. In determining proposed payments to hospitals, the commissioner shall take into account a facility's income from all sources, including specific purpose grants and other funds from governmental sources, but excluding income and principal from board or donor restricted funds, gifts and special fund raising projects.

To establish and maintain a fair and equitable system for determining such payments, the commissioner shall require each

health care facility to report such financial, statistical and patient information as may be required, in accordance with a uniform system of reporting established by him. The commissioner may propose regulations for approval by the board which assess penalties for failure to report such information within such time as may be prescribed therein.

N.J.S.A. 26:2H-18.1

26:2H-18.1. Preliminary cost base, certified revenue base or schedule of rates; adjustments; determination and review by commission; regulations

a. The commission shall make the determinations and hear appeals provided for in this act in a timely manner pursuant to regulations proposed by the commissioner and approved by the board. Such regulations shall be presented to the Standing Legislative Committees on Institutions, Health and Welfare for final approval within 1 year following establishment of the commission pursuant to the provisions of this act, and shall remain in effect in the form proposed by the commissioner and approved by the board until the provisions of such regulations are enacted into law as amendments to this act. Such regulations shall require that in the event the commission does not perform its duties within the time period specified therein the commission may permit a hospital to make a temporary reasonable change in rates which shall be effective immediately, when it deems it in the public interest to do so. Notwithstanding such temporary change in rates, the review procedure set forth in this section shall be conducted by the commission as soon thereafter as is possible.

b. Pursuant to regulations proposed by the commissioner and approved by the board, the commissioner shall propose and the

commission shall make automatic periodic adjustments to each preliminary cost base or certified revenue base for changes in economic factors reasonably calculated to provide for the effects of general economic inflation or deflation; for industry wide changes in the efficiency of delivering health care services; and for each hospital's actual changes in volume and case-mix, which are necessary and appropriate. The commission shall approve an appropriate change in the schedule of rates to reflect these adjustments.

c. Pursuant to regulations proposed by the commissioner and approved by the board, the commission shall consider adjustments to the certified revenue bases and schedules of rates, provided such adjustments: (1) result from statutes and regulations affecting the delivery of health care; and (2) may affect one or more hospitals. Such adjustments shall take into account the effectiveness and efficiency of the health care delivery system as a whole. Where appropriate the commission may sit en banc and hold public hearings in order to obtain the evidence required to support its conclusions and determinations. In the case of such hearings the commission shall provide actual notice to the affected planning and licensing authorities and hospitals, and to the commissioner and the Public Advocate.

d. Pursuant to regulations proposed by the commissioner and approved by the board, all other changes in the commission's determinations shall require a review by the commission in a public hearing of the entire preliminary cost base or certified revenue base and schedule of rates. Determinations of the commission may be appealed by hospitals, the commissioner, the Public Advocate, affected planning, licensing or inspection agencies and payors, and other affected parties, and shall be conducted as contested proceedings under the Administrative

Procedures Act, P.L. 1968, c. 410 (C. 52:14B-1 et seq.). During the pendency of any appeal, the schedule of rates approved by the commission pursuant to sections 5 and 10 of this act[1] shall remain in effect.

In all appeals, the burden of proof shall be on the petitioner. All determinations rendered hereunder shall be consistent with regulations and shall set forth in detail the commission's reasoning and conclusions regarding the parties and considerations specified in this act.

P.L. 1971, c. 136, § 18

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18.

a. No government agency and no hospital service corporation organized under the laws of the State shall purchase, pay for or make reimbursement or grant-in-aid for any health care service provided by a health care facility unless at the time the service was provided, the health care facility possessed a valid license or was otherwise authorized to provide such service.

b. Payment by government agencies for health care services provided by a health care facility shall be at rates established by the commissioner, based on elements of costs approved by him.

c. The Commissioner of Health in consultation with the Commissioner of Insurance shall determine and certify the costs of providing health care services, as reported by health care facilities, which are derived in accordance with a uniform system of cost

1. Sections 26:2H-4.1, 26:2H-18.

accounting approved by the Commissioner of Health. Said certification shall specify the elements and details of costs taken into consideration.

d. Payment by hospital service corporations, organized under the laws of this State, for health care services provided by a health care facility shall be at rates approved as to reasonableness by the Commissioner of Insurance with the approval of the Commissioner of Health. In establishing such rates, the commissioners shall take into consideration the total costs of the health care facility.

P.L. 1991, c. 187, § 1

CHAPTER 187

1.[1] (New section) The Legislature finds and declares that:

a. Access to quality health care shall not be denied to residents of the State because of their inability to pay for the care; there are many residents of the State, particularly those with incomes below the federal poverty level, who cannot pay for needed hospital care and in order to ensure that these persons have equal access to hospital care it is necessary to maintain a mechanism which will ensure payment of uncompensated hospital care; and to protect the fiscal solvency of the State's general hospitals, as provided for in P.L. 1971, c. 136 (C. 26:2H-1 et al.), it is necessary that all payers of health care services share equally in the payment of uncompensated care on a Statewide basis.

b. The "New Jersey Uncompensated Care Trust Fund," created pursuant to P.L. 1986, c. 204, and continued pursuant to

1. N.J.S.A. 26:2H-18.24.

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P.L. 1989, c. 1 (C. 26:2H-18.4 et seq.), which law expired on December 31, 1990, by which hospitals were able to collect their reasonable cost of approved uncompensated care, resulted in unobstructed access to health care for reidents without insurance who otherwise are unable to afford care.

c. Having received and thoroughly reviewed the reports issued by the Commissioner of Health and the Governor's Commission on Health Care Costs on uncompensated care, its economic implications and various means of financing uncompensated care, it is evident that provision for a trust fund is necessary, with modifications, to ensure access to hospital care for those who cannot afford to pay and the fiscal solvency of hospitals. At the same time, the State should take further actions to: provide more comprehensive Medicaid coverage for the medically indigent, reduce the rate of increase in health insurance premiums and explore and implement various initiatives to reduce the amount of uncompensated care in this State without impairing access to care.